



# Direct Member Reimbursement Claim Request

## PART ONE: To be completed by you

MEMBER ID

PATIENT NAME

CUSTOMER ID

PATIENT'S DATE OF BIRTH (MM/DD/YY)

MEMBER NAME

SEX:  MALE  FEMALE

RELATIONSHIP:

SUBSCRIBER  SPOUSE  CHILD

OTHER: \_\_\_\_\_  
EXPLAIN RELATIONSHIP

MAIL ADDRESS - STREET

CITY

STATE

ZIP

DAYTIME TELEPHONE

I certify that I (or my eligible dependent) have received the medication described herein and that the patient named is eligible for drug benefits. I also certify that the medication received is not for the treatment of an on-the-job injury, or covered under another benefit plan unless Part Two is completed. I authorize release of all information pertaining to this claim to Argus Health Systems, Inc., the plan administrator, insurance underwriter, plan sponsor, policyholder, and/or employer. I certify that all the information entered on this form is correct.

SIGNATURE OF PATIENT, GUARDIAN OR LEGAL REPRESENTATIVE

## PART TWO: Coordination of Benefits (COB)\*: To be completed by you

**YOUR POLICY/PLAN MUST HAVE A PHARMACY COB CLAUSE IN ORDER TO COORDINATE BENEFITS.**

HAS YOUR CLAIM BEEN PROCESSED WITH ANOTHER INSURANCE CARRIER?

NO If no, you can skip the remainder of Part Two.

YES If yes, attach a **copy** of: your explanation of benefits (EOB) or statement from the other coverage and/or your receipt from the pharmacy.

NAME OF INSURED POLICYHOLDER

NAME OF INSURED'S EMPLOYER

NAME OF OTHER INSURANCE COMPANY

TYPE OF COVERAGE  SINGLE  FAMILY

POLICY NUMBER (OTHER INSURANCE COMPANY)

### PRESCRIPTION #1

Tape Pharmacy Receipt Here  
Cash register receipts are not acceptable

### PRESCRIPTION #2

Tape Pharmacy Receipt Here  
Cash register receipts are not acceptable

## PART THREE: Pharmacy Information - To be completed by you or your pharmacist

PHARMACY NAME

ADDRESS - STREET

NPI NUMBER

CITY

STATE

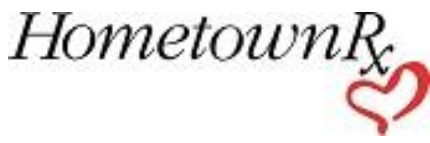
ZIP

PHARMACY TELEPHONE

### FOR COMPOUNDS

**For Compounds:** Pharmacist must identify the specific prescription by date of service and Rx number. Please list name, National Drug Code (NDC) # and metric quantities of each ingredient in box on left.

SIGNATURE OF PHARMACIST FOR COMPOUNDS



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## HOW TO COMPLETE THIS FORM

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*Complete the following (please use a separate claim form for each family member)*

**Note: Claim submission is not a guarantee of payment.**

### PART ONE

#### Subscriber Information

1. Member ID: The Member ID copied exactly from the ID Card.
2. Member name, address, and telephone number.
3. Patient Name: Person for whom the drug was prescribed.
4. Patient Date of Birth: Month, Day, Year.
5. Patient Sex: Check Male or Female
6. Status: Patient's relationship to subscriber. If other, please write in the type of relationship.

### PART TWO

**Coordination of Benefits (COB) is the process of determining which of two or more insurance policies will have the primary responsibility of processing/paying a claim and the extent to which the other policies will contribute.**

1. If you **do not** have Coordination of Benefits (COB) coverage, check No.
2. If you **do** have COB coverage, check Yes, complete Part Two, and attach a **copy** of: Explanation of Benefits (EOB) or statement from other coverage and/or pharmacy receipt.
3. Name of insured policyholder.
4. Name of insured individual's employer.
5. Name of other insurance company.
6. Insurance policy number from other insurance company.

### PART THREE

#### Pharmacy Information

1. Pharmacy name, address, and telephone number where the prescription(s) were purchased.
2. National Council for Prescription Drug Program (NCPDP) ID: Obtain the number from the pharmacy where prescriptions were purchased.
3. Tape pharmacy receipts to the form in the space provided. The receipts must indicate **date of service, Rx number, NDC number, quantity, days' supply** and the **amount paid**. Cash register receipts are not acceptable for any prescriptions.
4. Use a separate claim form for each pharmacy from which you purchase prescriptions.

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## MAIL THIS FORM TO

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#### HometownRx

10315 Professional Circle

Reno, NV 89521

Fax: 1-866-521-9916